



Initiation of Antiarrhythmic Drug

Fax to: (206) 685-7569

or (800) 253-6404

Complete this form for administration of antiarrhythmic drug during baseline hospitalization only.

1 Date first drug started: **days09**

/ /
Month Day Year

- -
Affix Patient ID # Here **seqnum09**

2 Drug assigned at randomization

Amiodarone - complete the following

Result of dosing:

1 Started, patient discharged on amiodarone

Cumulative dose (mg) given during in-hospital loading phase:

mg **asgtam09**

2 Started but discontinued prior to discharge

Specify the reason which best describes why:

1 Intolerable adverse symptoms (complete the Adverse Symptoms form)

stpmi09

2 Patient died

3 Other:

0 Never started

Specify reason:

1 Patient refused

nvrarni09

2 Patient died

3 Other:

Sotalol - complete the following

Result of dosing:

1 Started, patient discharged on sotalol

Daily dose (mg) at discharge:

mg **asgsmg09**

2 Started but discontinued prior to discharge

Specify the reason which best describes why:

4 Inefficacy

stpsot09 **1** Intolerable adverse symptoms (complete the Adverse Symptoms form)

2 Patient died

3 Other:

0 Never started

Specify reason:

4 Insufficient ectopy/ noninducible

nvsot09 **1** Patient refused

2 Patient died

3 Other:

63487

Initiation of Antiarrhythmic Drug

Date first drug started:

--	--

 /

--	--

 /

--	--	--	--	--

Month Day Year

--	--	--

 -

--	--	--	--	--

 -

--	--	--	--	--

Affix Patient ID # Here

- 3. If the patient was discharged on something other than (or in addition to) the assigned drug therapy, please specify what the therapy was at discharge (check all applicable).**

dscnon09 No antiarrhythmic therapy

dscami09 Amiodarone

For amiodarone, cumulative dose (mg) given during
in-hospital loading phase:

--	--	--	--	--

mg **dsctam09**

dscsot09 Sotalol

dose:

--	--	--

mg/day **dscsmg09**

droth09 Other antitarrhythmic drugs:

--	--	--	--	--	--	--	--	--	--

dose:

--	--	--	--	--	--

mg/day

--	--	--	--	--	--	--	--	--	--

dose:

--	--	--	--	--	--

mg/day

dscicd09 ICD (Notify CTC prior to implantation - This is a crossover. Complete Change of Therapy and ICD Implantation forms)

Signature of person filling out this form

--	--	--	--

code number

For Clinical Trial Center Use Only: **rtnum09**

				Yes <input type="radio"/>	No <input type="radio"/>						
						2 0 9 0 3 0 0					
DRUGINIT page 2 of 2 07/15/94											